TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JEFFERY POTTER, DC

Respondent Name
TRAVELERS INDEMNITY CO OF CONN

MFDR Tracking Number
M4-15-3813-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JULY 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IN THIS CASE, 99358 WAS USED TO DOCUMENT THE NON FACE TO FACE TIME WHERE DR POTTER REVIEWED DR BROWN'S REPORT DATED 12/19/14. IT IS ENCLOSED."

Amount in Dispute: $95.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for CPT code 99358…The Provider alleges they are entitled to reimbursement for non-face-to-face case evaluation time spent reviewing the report from the Carrier's Required Medical Evaluation. In support of their contention, the Provider references Rule '134.204(A)' and its case management criteria. Rule 134.204(e) addresses case management, and instructs providers to utilize CPT codes 99361 through 99373. CPT code 99358 is not included in this rule, and therefore the Provider's reference does not support reimbursement. Further, the Carrier has reviewed the documentation and position statement of the Provider. Review of standard medical records is part of the administrative requirements for treating workers compensation claims, and not subject to separate reimbursement under the Medicare-based fee schedules. The Provider references a date of service to which the review is related that is over 6 months prior to the date of service at issue herein. This cannot reasonably be stated to be a record review on 01-14-2015 related to an office visit on 06-20-2014. The Carrier contends the Provider is not entitled to separate reimbursement for CPT code 99358."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2015	CPT Code 99358 Prolonged Evaluation and Management Service	$95.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97, 243-Allowance included in another service.
   - 193-Original payment maintained.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Does the documentation support billing CPT code 99358? Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for CPT code 99358 based upon reason codes "97" and "243."

   CPT code 99358 is defined as "Prolonged evaluation and management service before and/or after direct patient care; first hour."

   The requestor wrote "IN THIS CASE, 99358 WAS USED TO DOCUMENT THE NON FACE TO FACE TIME WHERE DR POTTER REVIEWED DR BROWN'S REPORT DATED 12/19/14. IT IS ENCLOSED."

   The Division reviewed the report and finds that the requestor wrote that the prolonged services was performed "in order to correct the patient's injuries that occurred" on the examination performed on June 20, 2014. The respondent continues to deny payment based upon "The Provider references a date of service to which the review is related that is over 6 months prior to the date of service at issue herein. This cannot reasonably be stated to be a record review on 01-14-2015 related to an office visit on 06-20-2014." A review of the submitted documentation does not support billing of code 99358. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/21/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.